Reservoir Court, Eden Unit, Northcroft Site

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

We found the following issues that the trust needs to improve:

- We were concerned about the safety of the ward environment. The layout of the ward offered poor lines of sight to assist staff in monitoring patients. We saw high-level ligature points around the ward; the trust had not adequately addressed these through the trust's ligature risk assessment and management plan. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.
- We had concerns about the robustness of the governance arrangements in relation to assessing, monitoring and lessening risks of ligatures in the patient care areas. Whilst ligature risk assessments and action plans were in place, they did not address all ligature risks and there was an unacceptable number of ligature risks remained on the wards.
- The trust had not reviewed ligature risks following incidents in a timely manner.
- Staff did not routinely update risk assessments and management plans. They did not always reflect incidents reported. This means that staff could be unaware of any risks the patients may pose to themselves or others, or it could lead to inconsistent management of incidents.
- Staff patient observations did not always carried out correctly or accurately recorded. This could compromise patient safety.
- Many of the care plans were not up to date and did not always reflect need. There was a lack of care planning for mental health needs; only 10 of the 24 care plans we reviewed had a mental health care plan in place. These were not holistic, recovery focused or personalised. Staff had not updated seven 72-hour care plans, despite, the patients being in hospital for more than two weeks, in five cases, the patients had been in hospital more than three weeks.
- We were not assured that the ward always had sufficient numbers of staff to make sure they could meet patients care and treatment needs. Despite the use of bank and agency staff, over the last three months prior to inspection, the ward had been left

Summary of findings

with one qualified nurse (instead of two) on 11 shifts. Medical cover was not always in place and as a result, patient's treatment had been delayed. Most staff had not had a yearly annual review.

- Governance arrangements on the ward were weak in relation to assessing, monitoring and improving the quality of care plans and risk assessments. We did not see any care record audits in place. There were no systems to ensure regular reviews and updates of care records. The ward had received verbal feedback following a routine CQC Mental Health Act review concerning poor risk assessments and care plans. We were concerned that the trust had not been addressed this after the feedback.
- The staff we spoke with had concerns about the new management structure and the changing criteria of the ward. They did not feel that the process had been smooth and were not clear in which direction the ward was developing.

However,

- The ward had a wide range of non-nursing professionals in place to develop and support patient care.
- The trust had employed a "User Voice" worker. They visited the ward regular to gather feedback from patients, which would then be fed back directly to the ward staff.

Summary of findings

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Background to Reservoir Court, Eden Unit, Northcroft Site

Birmingham and Solihull Mental Health Foundation Trust provide acute mental health in patient care from a number of sites across Birmingham and Solihull. Reservoir Court is based on the Northcroft site. It was part of the older adult mental health in patient services until May 2016, when it transferred to the adults of working age services.

Reservoir Court offers inpatient admissions to adults with mental illness who have additional physical health needs.

The CQC had undertaken a comprehensive inspection of Birmingham and Solihull Mental Health Foundation Trust in May 2104. At that time, Reservoir Court was part of the core services for older people. This core service had been rated overall as requires improvement. However, Reservoir Court had not been inspected during that inspection.

A Mental Health Act (MHA) review was undertaken on 22 October 2016. This was part of the CQC MHA monitoring schedule.

Our inspection team

The team was comprised: two CQC inspectors, one CQC inspection manager and one Mental Health Act reviewer.

Why we carried out this inspection

This was an unannounced inspection to follow up on concerns identified during a Mental Health Act monitoring visit on 22 October 2016. The concerns were poor risk assessment and care planning.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services.

On the day of the inspection, the ward manager was on leave. One permanent qualified nurse was attending the planned multidisciplinary meeting and the other qualified nurse was bank. We requested that the senior site manager attend to support staff during the inspection.

During the inspection visit, the inspection team:

- visited Reservoir Court and looked at the quality of the ward environment
- observed how staff were caring for patients
- spoke with four patients who were using the service
- spoke with one carer
- spoke with the clinical matron for Reservoir Court

Summary of this inspection

- spoke with eight other staff members; including doctors, nurses, occupational therapists and psychologists
- attended and observed one hand-over meeting and one multi-disciplinary meeting
- looked at 25 treatment records of patients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients we spoke to on the ward indicated that they were comfortable and felt safe. One patient told us they liked the activities and another said the ward was good. A carer we spoke with did not feel that staff gave up to date information about their relatives care.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- We found numerous ligature risks on the ward.
- The layout of wards meant staff could not observe all areas with a clear line of sight.
- We were not assured that staff always followed correct procedures for nurse patient observations. We found inaccurate records and an incident where staff had not undertaken allocated observations.
- Logs that recorded maintenance and checks of equipment were not always fully completed.
- Staffing levels did not always meet agreed establishment levels and there was a high reliance on agency and bank staff. We were not assured that bank and agency staff were thoroughly inducted.
- Staff did not routinely update risk assessments following admission and after incidents. Risk management plans did not reflect patient needs.

However

- The ward was visibly clean and the furnishings were well maintained.
- Staff were good at reporting incidents; they were open and transparent to patient and carers when things went wrong.

Are services effective?

- The nursing staff did not routinely update 72-hour care plans after 72 hours. This meant staff did not assess patient' needs and completed care plans in a timely manner.
- Only ten patient care records out of 24 patients patient care records we reviewed had a mental health care plan in place. These were not holistic, personalised or recovery orientated.
- Only two of 19 nursing staff had an up to date annual development review in place. Three staff had a planned date for their annual development review. The remaining 14 staff had no plans for a review in place.

However

- Assessment and monitoring of physical health care was good and staff referred patients to other specialists as needed.

Summary of this inspection

- Where staff had assessed patient's capacity to consent to admission, we found they had recorded their reasons for arriving at their decisions, and correctly recorded the outcome of the assessment.

Are services caring?

- We observed staff to be kind and caring, respectful and warm in their interactions with patients and carers.
- Patients had copies of their care plans on the notice boards in their bedrooms.

However,

- We noted from the care records reviewed that there were no advance decisions in place for any of the patients. Although staff were recording that they had checked whether any advance decision existed, there was no evidence that staff were discussing with patients how to make their wishes and views about treatment known in advance.

Are services responsive?

- The trusts delayed discharge nurse assisted staff from Reservoir Court to review delayed discharges.
- The ward had a full range of rooms and equipment to support treatment and care, for example, clinic rooms, therapy rooms, quiet areas and a visiting area.
- The ward had suitable adjustments for patients requiring disabled access and was able to provide the patients with equipment to increase their independence and dignity.

However,

- Patients did not always have access to beds on return from leave and at times had to transfer to wards in other parts of the trust.

Are services well-led?

- The trust did not have systems in place to ensure staff completed risk assessments, risk management plans and care plans in a timely manner, which reflected the needs of the patients.
- The trust had not reviewed its ligature risks and plans to reduce those risks following incidents in a timely manner.
- Staff were unsure as to the way the ward was developing in terms of patient group and care it provided. They did not feel that the transition from the older adult management structure

Summary of this inspection

to the inpatient for adults of working age structure was clear, they did not seem to know in what direction the ward would be developing and if the needs of patients to be admitted would be significantly different.

Acute wards for adults of working age and psychiatric intensive care units

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are acute wards for adults of working age and psychiatric instensive care unit services safe?

Safe and clean environment

- The layout of the ward did not allow staff to observe all parts of the ward and as such had numerous blind spots. Staff told us they were aware of the risks to patients' safety caused by the layout. To reduce these risks, staff said they assessed individual patients' risks and increased observation in blind spot areas. For example, staff said they would routinely walk around the ward and check areas that were away from the main lounge. The ward did not have any mirrors installed to aid nursing observations.
- Staff had completed a ligature risk audit tool to identify ligature points. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. It had highlighted ligature points on the ward and in the gardens. This was due for review November 2016.
- The trust had documented control measures to minimise the risk of ligature points against each ligature point risk identified. These included; patient risk assessment, use of observation, locking of doors and staff supervision of the environment. We were concerned that the trust had not considered removing certain ligature points or fit an anti-ligature alternative. We found risk assessments to be poor (this will be discussed later in depth later in the report); we did not think that patient risk assessments could be relied upon to reduce risks from ligatures.
- We did note that windows in the patient bedrooms were anti-ligature.
- We asked staff if the trust had reviewed ligature risks since a fatal incident involving a ligature that had occurred one month earlier. Staff told they us had not been, but there was a planned review for 7 December 2016.
- The trust had not identified bedrooms with less ligature risk for patients identified as a higher risk of self-harm.
- Staff kept ligature cutters with the emergency bag in the reception office. All staff we spoke with except one member of bank staff knew where the location of the emergency equipment. Staff we spoke with knew how to use the ligature cutters.
- The ward complied with Department of Health guidance on mixed gender accommodation. Male and female bedrooms and bathroom facilities were on separate corridors. There were separate male and female lounge and dining areas.
- We saw the clinic room was visibly clean and tidy. They were well equipped with clinical observation equipment such as blood pressure monitors, pulse oximeter and blood glucometer. Clinic couches had disposable sheets available.
- We looked at the emergency bag and found it included emergency resuscitation equipment and emergency drugs. We reviewed the logbook to ensure staff completed and recorded daily checks of the emergency bag. Overall, staff kept it in good order. However, we found five dates between September 2016 and November 2016, which had not recorded to confirm that staff had completed a daily check. We could see in the log that staff had used the equipment in an emergency and then restocked immediately.
- We saw that staff mostly kept medical equipment clean, maintained and calibrated. However, we identified several gaps where staff had not recorded daily

calibration of the blood glucometer. Staff had not recorded five days between 30 October 2106 and 14 November 2016. Staff had also missed 12 days in September 2016.

- We noted one wheelchair in the corridor that had no footplates. Staff told us the wheelchair was not in use. The wheelchair did not have a label stating it was out of use and could have been used unknowingly ward staff or relatives. Staff should ensure wheelchair have footplates should be used to increase patient comfort and safety.
- Reservoir court did not have a seclusion room. Staff reported they did not use seclusion on the ward. We did not see any evidence that staff used other rooms to seclude patients.
- All wards were visibly clean, had good furnishing and well maintained. Domestic staff followed schedules for cleaning. We reviewed cleaning schedules for the ward, mobility equipment and mattresses. We could from the schedules that staff did not always sign to state that they had completed tasks. Staff said they followed schedules but often forgot to sign that they had completed the tasks despite reminders to do so.
- We observed good hand hygiene and infection control in practice. There were laminated hand hygiene posters displayed in clinic and toilet areas explaining and promoting good hand hygiene. Hand gel dispensers were available to staff and patients. The ward had a health care assistant who was infection control lead.
- Staff completed infection control audits. The last audit completed quarter two (2016) indicated that staff had achieved 100% correct practice. This was an improvement from quarter one (2016) whereby they had achieved 95%. This showed that the staff had followed guidance from the audit to improve on infection control.
- All patient bedrooms and bathrooms had nurse call buttons, so patients could summon assistance if needed.
- All staff carried personal alarms to summon assistance if needed.

Safe staffing

- The trusts staffing establishment for Reservoir court was:
  - One whole time equivalent (WTE) band 7 registered mental health nurse (RMN)
  - Two WTE band 6 RMN
  - 11.5 WTE band 5 RMN
  - 12 WTE band 3 health care assistants (HCA)
- The ward had four RMN vacancies. The manager informed us the trust had recruited into two of these posts. The prospective staff were waiting start dates.
- There were no HCA vacancies.
- Two qualified nurses were on long-term sick leave.
- One HCA was on maternity leave and another on long-term sick leave.
- The sickness rate for the twelve months prior to inspection was 7.7%. The national average sickness rate is 4.2%.
- The trust had increased staffing levels for each shift in May 2016. Managers told us the trust planned a further staffing review within the next two months.
- The ward had three shifts each day. Each shift set staffing levels of:
  - seven staff on an early shift (three RMN and four HCA)
  - six staff on a late shift
  - five staff on a night shift
- We reviewed rotas from 1 August 2016 to 22 November 2016. We found the number of nursing staff booked on each shift matched the establishment level. However, there were staffing shortages reported due to unexpected sickness or inability of agency or bank to provide actual cover.
- We saw from incident records that staff completed incident forms when actual staffing levels dropped below establishment. We reviewed incident forms completed between 4 August 2016 and 19 November 2016. Staff had reported 11 shifts where staffing levels did not meet agreed levels. Eight of these shifts had been short of qualified nurses, leaving one qualified nurse on the shift. Staff documented on incident forms how it had affected patient care and nursing practice.

For example, one form documented that the ward only had qualified nurse on duty and the nurse on duty had administered a controlled drug without a second qualified witness.

- In addition, they had noted that at these times a single nurse was left to manage a ward of 24 patients with complex physical and mental health needs and a team of HCA's. Staff said it also meant that they could not always assist with escorts and qualified staff would be unable to take a break.
- Staff and rotas confirmed that there was a high use of bank and agency staff. Permanent staff we spoke with told us that bank and agency were mostly regular to the ward, but not all the time. This meant that they needed to ensure staff were familiar with the ward and routine.
- In addition, an incident form we reviewed completed in September 2016 showed that an agency member of staff had not correctly completed level three patient observation duties. Level three observations are when a patient should always be within eyesight of a member of clinical staff. Agency, bank and one permanent member of staff had staffed the shift. The review of the incident had found that bank, agency staff had been changing their allocated tasks without informing the nurse in charge, and tasks had been missed. This would indicate that agency and bank staff are not always fully inducted and aware or familiar with the ward and patient care needs.
- We found that in four out of ten patient care records, staff had not updated observation levels recorded in risk management plans.
- Three risk management plans did not include the observation levels, but in one case, there was an observation care plan in the patient's records that did clearly record the level of observations.
- During the inspection, we saw that a qualified nurse was present in both the male and female communal areas, as well as HCA staff.
- Staff told us that patients had one to ones from nurses or other member of the multi-disciplinary team.
- Staff told us that during the day they had access to a junior doctor. The ward had two consultants who shared one whole time equivalent post. Staff accessed the duty on call doctors out of hours. Staff told us access to doctors could be problematic.
- We found four reported incidents between 4 August 2016 and 19 November 2016, where nursing staff had reported difficulty accessing a doctor. Two of these were due to inadequate cover for the ward consultants' annual leave. The other two incidents reported regarded junior doctor cover that had resulted in tasks being handed over to the out of hours doctor on call. Staff had highlighted one patient had to wait several hours before being examined by a doctor, prior to medication being prescribed. Staff told us that they had shared their concerns with the clinical director, but were unaware of any follow up plans to address the issues.
- Staff told us they would contact emergency services in a medical emergency.
- Data provided by the trust indicated that most eligible staff had completed or was booked on to mandatory training. Mandatory training included management of aggression and violence (AVERTS) clinical risk assessment, clinical supervision, dual diagnosis, fire safety, food hygiene, equality and diversity, health and safety, health care records keeping, and infection control.

Assessing and managing risk to patients and staff

- Staff told us they did not use seclusion and we could find no evidence to suggest that they did.
- During this focused inspection we did not gather data on the use of restraint.
- We looked at 25 patient care records. All had a risk assessment and management plan in place. We saw that the referrer had completed these on the day of admission. We could see that staff had only updated four of these the day after admission. This meant staff did not re assess risks on the ward in a timely manner.
- Staff had not updated ten of the risk assessments since the patient's admission. One patient record showed that staff had not updated their risk assessment since their admission five months ago. Two risk assessments had not been updated since admission for four months ago, a further three records showed no update since

admission 3 months ago. The remaining risk assessments had been updated between one and two months post admission. During our inspection, we only found two up to date risk assessments, which staff had reviewed in the two weeks prior to inspection. This is concerning as staff may not be working with up to date information and this may place patients and others at risk of harm.

- All patients had risk management plans in place. However, staff had not updated 12 of the risk management plans since the patients' admission or following incidents and changes in the patient presentation. For example, staff had reported a patient had assaulted others in five separate incidents over a period of time. Staff had not updated the risk assessment and management plan during that time.
- We also found one risk assessment and management plan that staff had not updated following a reported overdose. In this case, we could not find any recorded evidence that a discussion within the multi-disciplinary team had taken place to assess risk and we could find not find a recording in the care records that stated the patient's suicidal risk.
- We saw a set of care records that documented the patient had been disinhibited towards another patient. Staff had not updated the risk assessment to reflect the behaviour and there was no management plan stating how staff would care for the person to prevent future risks.
- One care record showed a patient had received five treatments of rapid tranquilisation over a period of two weeks. The risk assessment and management plan did not reflect the change in the patient's behaviour and again did not state how staff would care for the person to prevent future episodes. Despite the patient having been in hospital six weeks prior to the inspection they only had the initial 72-hour care plan in place. This care plan did not address the patient's risks or the use of rapid tranquilisation to manage the patient's agitation.
- One care record showed that staff had not updated a patient's risk assessment until the day of their discharge.
- Although we found that patients had fall risk assessments and care plans in place staff did not always update them following falls. One patient had fallen six times over a period of a month. We reviewed the care records and could see there had been no update to the falls assessment and plan. We could see this was inconsistent as other records we viewed showed a physiotherapist had updated falls risk assessments and plans when they had worked with a patient.
- We found no evidence to suggest staff used blanket restrictions. Staff told us they searched patients on admission. They only searched patients on return from leave if there was a clear risk, such as the patient was likely to bring banned items, such as alcohol, onto the ward. This was a proportionate response to the risks identified, and showed staff had considered the guidance in chapter one of the Mental Health Act Code of Practice concerning restrictions on patient.
- Staff we spoke with were aware of the trust observation policy and could explain how it worked in practice. We could see from minutes of staff meetings that staff were reminded of observations levels. We checked a sample of staff patient observation records. Records reviewed covered October 2016 to November 2016. We found the recording of observations was poor. It was not clear on the paperwork when dates changed after midnight. We found three sheets completed which were dated for the same 24 hour period, but had been signed by different staff. This indicated that it was a different shift, but staff had not recorded the dates accurately. It was not clear which record was accurate.
- We found a record of an incident from September 2016 where a patient on level three observations (this means that the patient should always be in eyesight of staff) was found wandering the ward with no member of staff observing them. This did not assure us that staff always undertook observations as per trust policy.
- We did not gather safeguarding training data on this inspection, but most staff we spoke to understood the principles of safeguarding, what and how they should report concerns. However, one member of staff told us they would always discuss safeguarding concerns with the manager before they were escalated. They were not aware that they had capacity to raise concerns independently.
- We found medicine cabinets locked and supplies were secure.

- Staff kept a record of fridge temperatures where medication was stored. We reviewed records and saw medications were stored within the appropriate temperature range.
- Staff did not record the clinic room temperature where medications were stored. This is important, as medicines should be stored in temperatures below 25 degrees in order to preserve their efficacy. If recordings are not noted then staff are unable to monitor if the room temperature if suitable for the storage of medication.
- We reviewed 23 patient medication charts. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them.
- Children visiting relatives had access to a visiting room on the ward.

Track record on safety

- There had been one reported serious incident in the last 12 months. This was a fatal incident. The trust had supported the staff and patients following the incident and followed the correct procedures for reporting the incident and contacting the family.

Reporting incidents and learning from when things go wrong

- Staff said they used the trusts electronic recording system to report incidents. Staff told us that they would report a range of incidents from assaults, safeguarding concerns, staffing issues, medication errors and accidents.
- We reviewed 107 incidents reported from 1 August 2016 to 19 November 2016 and the incidents forms we reviewed documented that staff were open and transparent to patients and carers when things had gone wrong with their treatment and care.
- The matron and service managers reviewed all incident reports completed and sent a report to the integrated quality team within the trust. Managers told us the integrated quality teams reviewed the incidents to look for themes or trends. The managers reported the trust fed back to staff across the trust via team meetings or email.
- Staff spoke of the recent support they had received from colleagues around the trust and following the recent incident. They said that staff and patients had received debrief and offered ongoing support.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

- Staff told us they followed trust policy on assessing needs and planning of care. On admission, the doctor clerks the patient and the named nurse is responsible for completing the initial 72-hour care plan based on the patients risk assessment. We looked at 25 patient care records. All patients had a care plan in place; however, only four were up to date.

  We found seven patients had a 72-hour care plan in place, which staff had updated despite the patient being in hospital for longer than 72 hours. Five of these patients had been in hospital for longer than three weeks and two of the patients had been in hospital for two weeks. These patients should have had an updated care plan in place.
- We found care plans did not always reflect mental health need. Most care plans focused on physical health care. We found a lack of care planning for mental health needs. Only 10 of the 24 care plans we reviewed had a care plan for mental health needs. These were brief and gave limited information. They were not holistic, personalised or recovery focused. They did not include the full range of patients' problems and needs. They were not personalised and did not include patients' views.
- Occupational Therapy (OT) staff had a clear clinical assessment pathway with standardised assessment measures including the model of human occupation screening tool (MoHOST).
- Staff told us that not all bank staff had access to the electronic care records. This meant permanent staff were left to complete entries and share information with bank staff. This could mean that staff did not always enter patient care information in a timely manner.

Acute wards for adults of working age and psychiatric intensive care units

Best practice in treatment and care

- Staff recorded fluid and hydration intake for all patients on admission. Staff reviewed that after three days and continued if needed.
- The psychologist said they were able to offer limited psychological therapies such as cognitive behavioural therapy (CBT) due to workload. They prioritised assessment and case formulation work. Case formulation, is a theoretically based explanation or conceptualisation of the information obtained from a clinical assessment. It offers a hypothesis about the cause and nature of the patients presenting problems. However, they could refer a patient for ongoing psychological interventions from the community service, if appropriate.
- The junior doctor completed all physical health examinations on admission. Care records we reviewed documented good physical health monitoring. We could see staff referred patients onto other specialists for physical health care when needed.
- The OT and psychologists used standardised assessments such as the Addenbrookes Cognitive Examination (ACE).
- Staff completed infection control audits.

Skilled staff to deliver care

- The staff team on the ward included a full range of appropriate disciplines. There was an OT, activity worker, psychologist, psychiatrist, nursing staff, administrator and housekeeper.
- A complimentary therapist visited the ward weekly and offered therapies such as relaxation.
- Reservoir Court had a physiotherapist who attended most days. They offered initial assessment to each newly admitted patient and would take referrals from the MDT.
- Only two of 19 nursing staff had an up to date annual development review in place. Three staff had a planned date for their annual development review. The remaining 14 staff had no plans for a review in place.
- Staff said that supervision was irregular. Management informed us that they were aware the staff had not received regular supervision and the ward manager would put an action plan in place.
- Data shared by the trust showed that staff were mostly up to date with mandatory training. Staff reported they had access to computer based e learning.

Multi-disciplinary and inter-agency team work

- We observed one multi-disciplinary team (MDT)ward round. A range of professionals attended it. Ward rounds are a meeting where professionals and patients meet to review and plan patient's care. We observed that the discussions focussed on discharge plans. However, the discussions did not always conclude with a summary of the care plan.
- We attended one nursing handover meeting. The nursing staff discussed all 24 patients, including; feedback from the earlier MDT, any concerning behaviours and a review of physical health needs and medications. Managers told us that they were planning to use the 'WHAT' hand over tool. WHAT is a standardised handover tool that the trust piloted earlier in 2016. The team want to adapt the tool to make it more relevant to caring for a patient group with additional physical health needs.

Adherence to the MHA and the MHA Code of Practice

- Mental Health Act (MHA) paperwork was scrutinised by the qualified nurse on admission.
- Staff we spoke to were aware of who and how to contact the trusts MHA administrator.
- Patient leave was authorised on a standard form, and included information about the length of time, escorts and other conditions. However, there was no space on the form to indicate whether the patient or carer had received a copy. In two cases, there was no contingency plan on the form.
- The ward is accessible via a flight of stairs or a lift, which opens straight on to the ward. Only staff can operate the lift. Staff kept the door to the ward locked. We saw a sign on the door that informed informal patients of their right to leave the ward and how they could request this. However, it would be difficult for informal patients to exercise their right to leave without assistance from staff.

Acute wards for adults of working age and psychiatric intensive care units

- Independent mental health advocacy (IMHA) service information was displayed on the ward. Leaflets were also available. The IMHA attend the ward by appointment only. Staff said they made referrals for patients.
- There was a "rights register" on the electronic recording system. Staff filled this in correctly in one out four cases, but none of the records we reviewed met all the criteria set out in the MHA Code of Practice. For example, none of the records showed whether staff had informed the patient of their right to appeal or seek independent legal advice.
- We noted there were no advance decisions in place for any of the patients whose notes we reviewed in full. Although staff were recording that they had checked whether any advance decision existed, there was no evidence that staff were discussing with patients how to make their wishes and views about treatment known in advance.

Good practice in applying the Mental Capacity Act (MCA)

- We did not collect data for Mental Capacity Act (MCA) training on this inspection.
- Staff we spoke with had an understanding of the basic principles of the MCA and Deprivation of Liberty Safeguards (DoLS).
- There were no patients subject to the DoLS on the ward at the time of the inspection. Although we found no evidence that patients were being deprived of their liberty, we drew the trust's attention to the ward's location, the locked door, and the physical health issues of the patient group, all of which may make it more likely that a patient lacking capacity might be deprived of their liberty in this setting.
- Where staff had assessed patient's capacity to consent to admission, we found they had recorded their reasons for arriving at their decisions, and correctly recorded the outcome of the assessment. In one case, the assessor had not noted whether the patient had any impairment of the mind or brain, as required by the Mental Capacity Act (MCA).
- We found records showing that staff involved family members in the assessment of capacity, to support the patient.
- Staff told us they would seek advice regarding the MCA from the Mental Health Act administrator.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Kindness, dignity, respect and support

- We observed staff interactions with patients and carers. They were warm, friendly and respectful.
- Staff were observed supporting patients over the lunchtime. They gave people support as needed and did not rush them.
- We observed privacy and dignity supported in many ways across the ward, for example, patients had a choice of different environments to eat their meals, and staff could give medicines the patient's bedroom or clinic. We saw staff knock on bedroom doors before entering.
- Relatives and carers were welcomed and supported in continuing with providing assistance with patient's personal care and activities of daily living if appropriate.

The involvement of people in the care they receive

- The trust employed a "User Voice" worker, who was responsible for encouraging user involvement in services, and ensuring that the patients' views are made known to staff. This worker visited the ward regularly. They had visited the ward in October 2016 to gain feedback from the inpatients at that time. Patients had reported activities on the ward were good, although one patient had reported there were not enough activities.
- The trust displayed advocacy posters throughout the ward. These explained what advocacy services offered and how patients could contact them. Staff we spoke with were aware of the advocacy services and how to make referrals to it.
- During the ward round we observed a carer being welcomed into the meeting, the patient was spoken to respectfully and included in the discussion of the proposed treatment and planned discharge.

Acute wards for adults of working age and psychiatric intensive care units

- Staff told us they included where possible all patients in the development of their care plan. Although we could not find any documented evidence of this.
- Patients had copies of their care plans on the notice boards in their bedrooms.
- The housekeeper worked with patients to create a themed window display in main corridor area.
- One carer we spoke with said that she did not agree with her relatives care package and staff had not offered her information about advocacy services. We asked staff to share this information with the carer.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Access and discharge

- We did not collect data on delayed discharges at this inspection. However, staff told us when discharges were delayed this was because of the need to set up complex care packages in the community in partnership with other social care agencies. Northcroft site had a nurse that works fulltime reviewing delayed discharges across the site. They supported staff on the ward with discharge plans.
- Staff told us patients do not always have a bed to return to after leave or if they returned early from planned leave. We were told, in this situation, the bed manager would allocate a bed elsewhere in the trust. At the time of the inspection, we were unable to identify how often this occurs.

The facilities promote recovery, comfort, dignity and confidentiality

- All 24 bedrooms were single and 16 had ensuite bathrooms. Where ensuite was not available, toilet and bathrooms were close by. Bedroom doors had adjustable viewing panels; this made night observations more discreet as to not disturb patients sleep.
- There was a good range of communal and gender specific rooms. This enabled patients to mix with each other, partake in different activities, or spend time in quiet areas.
- The decorations around the ward promoted comfort and interest. For example, there was a library area and a room with a piano.
- There were signs on doors so patients could identify the room. This could help orientate a person to the ward environment.
- The ward had an activity room equipped with various activities such as crafts, games and jigsaws.
- There was a relaxation room with sensory equipment to aid relaxation.
- Patients had access to well-maintained garden space that was also was equipped with appropriate handrails and seating areas.
- Patients had access to a payphone. The payphone could be wheeled to a quiet area to maintain privacy whilst making a phone call.
- Staff supported patients to maintain daily living skills where possible; patients could plate up their own meals or use the laundry.
- Bedrooms had lockable safes for patients to secure personal items or they could choose to store them in the staff office.
- Patients could access drinks and snacks at any time.
- A weekly activity programme was in place. It comprised of group and individual sessions. Examples of groups offered were reminiscence, relaxation, breakfast group and craft groups.
- Patients had access to daily newspapers.
- Patients had access to aids to promote independence, for example plate guards and adapted cutlery. The occupational therapist told us they were able to order independence aids as needed. One example they gave was a hair basin to use to wash a patients hair whilst in bed.

Meeting the needs of all people who use the service

Acute wards for adults of working age and psychiatric intensive care units

- The ward is on the first floor. It is accessible via stairs or lift. There were access ramps at the back of the ward via the fire exits to use in an emergency.
- There were facilities for people requiring additional support, including hoists and hydraulic beds. The ward had good wheelchair access. This meant the staff could effectively manage patients with physical needs well as mental health needs.
- There were information leaflets in different languages at the main receptions and on the numerous notice boards around ward. Leaflets included information about patient advice liaison services, independent mental health, detained patients rights, advocacy, and other support groups, CQC and how to complain.
- There was also information about physical and mental health treatments available., The wards could provide a variety of dietary requirements from finger food, soft, low potassium or culturally specific.
- The ward had a multi-faith room with washing facilities. Staff were able to arrange spiritual support for patients as needed.
- We observed staff kept some ensuite bathroom doors ajar. Staff did this by placing a towel over the top of the door creating a wedge. Staff told us this was because some of the older patients found the doors too heavy to open. Whilst it may increase a patient's independence to open the door, it creates a further ligature point risk.

Listening to and learning from concerns and complaints

- Managers told us that there had been one informal complaint in the six months prior to the inspection. A carer had contacted the ward directly to speak with the ward manager. We reviewed the documentation and could see staff had followed the correct procedure and dealt with the complaint appropriately.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Vision and values

- Staff told us they were uncertain about the recent management change from older adults to adults of working age. They were not clear if the patient group admitted to the ward would change significantly. They were not sure of the future vision for the ward.
- On inspection, staff informed us that Reservoir Court was now under the remit of inpatient wards for adults of working age. However, at the time of inspection the trust website showed that Reservoir Court was an older adult ward.

Good governance

- The ward had kept performance indicators in place to monitor and measure their performance: seven day follow ups following patient discharge, Care Programme approach reviews and patients who were absent without leave (AWOL).
- The trust had systems for monitoring ward staff compliance with supervision. However, they had not ensured that staff received regular supervision to ensure they had the right skills for their role and support. They had not ensured that staff had up to date annual performance reviews.
- We had concerns about the robustness of the governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. Whilst ligature risk assessments and action plans were in place, they did not address all ligature risks and an unacceptable number of ligature risks remained on the wards.
- We had concerns about the robustness of the governance arrangements in relation to assessing, monitoring and improving the quality of care plans and risk assessments. We did not see any care record audits in place. The ward manager and matron had received verbal feedback following a CQC mental health act review in 22 October 2016 that care plans and risk assessments were poor. During our inspection one month later, we found no improvement in care plans and risk assessments.
- We were not clear about the governance mechanisms in place. The ward struggled to have regular business meetings to cascade and discuss governance. We reviewed minutes from staff meetings. The ward aims to have a staff meeting every two months. Minutes showed

that clinical and non-clinical staff attended. There did not appear to be a standing agenda. Staff documented discussions had taken place, but decisions were not always recorded with actions and by whom. For example, one meeting highlighted the need to make the relatives leaflet more informative, but now actions or timescale had been identified.

Leadership, morale and staff engagement

- The ward manager had been in post for three weeks. Senior management told us the new ward manager would have daily contact from a senior manager for support and guidance.
- Three staff we spoke with described the current management structure and changes as problematic. One said that working across pathways was confusing and that the management structure was confusing. Another said that they were not sure what changes would be taking place to the ward now they were being managed by the adults of working age directorate.
- Another member of staff said that transition between management changes had been confusing. They did not feel that the new management have the same understanding of the needs of the ward and the patient group.
- Staff on the ward said they work well together. They described being a supportive team.

Commitment to quality improvement and innovation

- The ward was AIMS (Accreditation for Inpatient Mental Health Services) accredited for the period of 14 December 2015 to 14 June 2017. AIMS accreditation is a process sponsored by the Royal College of Psychiatrists, and measures standards on the ward against a range of criteria. External assessors carry out the assessment of the ward.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all patients have an up to date risk assessment and risk management plan and that these are reviewed and reflect changes in risks.
- The trust must take action to ensure ligature risk points are reduced and the ward environment is reassessed promptly following any ligature incidents.
- The trust must ensure staff carry out and record patient observations in line with trust policy.
- The trust must make sure all bank and agency staff aware of where lifesaving equipment is kept.
- The trust must ensure care plans meet the need of patients and that staff complete these in a timely manner.
- The trust must undertake audits of care records to ensure that any deficits in patients' care records are identified and amended.
- The trust need to ensure that all equipment is fit for purpose and that staff record logs of maintenance and calibration of equipment accurately.
- The trust must ensure that staff receive regular managerial and clinical supervision, as well as yearly appraisal.
- The trust must ensure that staffing levels and grade on shift meet the agreed standard.
- The trust must ensure that medical leave is consistently covered

Action the provider SHOULD take to improve

- The trust should ensure that staff record the temperature of the clinic room.
- The trust should document that patients have received a copy of their care plan.
- The trust should ensure that the vision and plans for the Reservoir Court are shared with and understood by all staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Patients did not have up to date risk assessment and risk management plans. • Risk assessments and risk management plans did not always reflect changes in risk. • Staff did not always carry out patient observations in line with trust policy. • The ward environment had a high number of ligature points; the trust had not adequately identified control measures to reduce these risks to patients. • Patient care plans did not always reflect need and were not regularly updated and reviewed. • Not all bank and agency staff knew where lifesaving equipment was kept. • The trust did not ensure that all equipment was fit for purpose. • Staff did not always maintain records for ensuring equipment was maintained and calibrated. This was a breach of Regulation 12 (1)(2)(a)(b)(d)(e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Staff reported and incidents forma showed that some shifts operated with one qualified nurse, which was below agreed establishment. • At times, there was inadequate medical cover.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 18 (1)(2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance This was a breach of regulation 17 (1)(2)(a)(b) • The trust did not have robust system or process in place to monitor and improve the quality and safety of care at Reservoir Court. • The trust did not have a robust process in place to reduce or remove risks identified.